

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
INVEGA(paliperidone)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- ▶ Minimum age - 18 years old.
- ▶ Diagnosis of schizophrenia.
- ▶ No prior therapeutic failure on risperidone.
- ▶ Not approved for use prior to trial of risperidone.
- ▶ Patient fails to take multiple daily doses of anti-psychotics and cannot tolerate a single daily dose of risperidone.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Updated letter of medical necessity.